



Northwest-Shoals Community College

2019-2020 Federal Loan Discharge Due to Disability

Disability Ln
Discharge

Instructions:

Our office has received information from the National Student Loan Data System (NSLDS) indicating that you have had one or more prior student loans discharged due to total and permanent disability. In order for our office to continue processing your financial aid, we need you to clarify whether or not you want additional loan consideration. Please allow 7-10 business days for processing, or longer during peak processing periods.

Student Information

Last Name (Print)	First Name (Print)	MI	Student ID Number
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Northwest-Shoals Email Address	Phone Number with Area Code
<input style="width: 95%;" type="text"/> @nwscc.edu	<input style="width: 95%;" type="text"/>

To Be Completed by Student:

Student Loan Information (Initial Below)

I do want to be considered for additional student loan funds.

- Complete Borrower Certification Statement.
- Your physician will need to complete the Physician's Certification Statement below.

I do not want to be considered for additional student loan funds.

- You will be considered for other types of assistance, but will not be considered for student loans.

Certification and Signature

I understand that neither any new loans(s) nor conditionally discharged loan(s) can be discharged on the basis of any present impairment unless it deteriorates so that I am again totally and permanently disabled.

Student's Signature (electronic signature NOT accepted)	Date
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Physician's Certification Statement

I certify that my patient (the student identified on this form) has a disability condition that has improved and that the student, has the ability to engage in substantial gainful activity. Note: the phrase "substantial gainful activity" generally describes a situation in which a student is sufficiently physically recovered to be capable of attending school, successfully completing a program of study, and securing employment.

Physician Signature	Physician Name (please print)	Date
Specialty	Office address (city, state, zip)	Phone Number

WARNING
If you purposely give misleading or false information on this form, you may be fined, be sentenced to jail, or both.